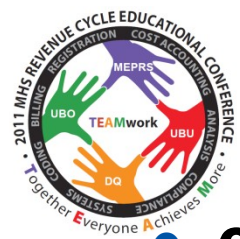




Title: **UBU Panel Discussion**

Session: **R-6-0900**



Overview

- **09:00-09:05 Introduction of UBU Members and Support Staff**
- **09:05-09:10 UBU update from Name Redacted**
- **09:10-09:15 Air Force update from Name Redacted**
- **09:15-09:20 Army update from Name Redacted**
- **09:20-09:25 Navy update from Name Redacted**
- **09:25-09:33 Air Force Questions & Answers**
- **09:33-09:41 Army Questions & Answers**
- **09:41-09:49 Navy Questions & Answers**



Air Force Q&A #1

- **Q:** We have two providers (both MDs) at our MTF who run an Acupuncture Clinic, they also teach providers at other MTFs how to perform “battlefield technique” acupuncture. Could you add coding guidance or send something out regarding the rules/regulations of the assignment of an E&M along with the acupuncture CPT codes?
- **A:** CPT has good instructions on use of acupuncture codes. These are time-based codes, which are counted as only face-to-face time, not the needle placement time. E&Ms may be reported in addition to acupuncture services when there is a documented separately identifiable condition that goes above and beyond the acupuncture service.



Air Force Q&A #2

- **Q:** RNDs; UBU 2011 CGs 9.2.3 Diagnosis; “The coding will reflect what is addressed each day; except for the discharge day when non-surgical admissions coding reflects the discharge diagnoses as outlined in the discharge progress note or narrative summary.” Shouldn't the discharge day for the surgical admission examples under 9.5.6, Professional Services Scenarios for Inpatient Encounters, be coded the appropriate aftercare code?
- **A:** The diagnosis will become an aftercare V code for any rounds post surgery. The discharge day diagnosis will reflect the reason for the admission/surgery to the hospital. Examples in 9.5.6 for discharge are correct as the surgical discharge diagnosis will be the reason for surgery.



Air Force Q&A #3

- **Q:** Consults; UBU 2011 CGs 4.1. Consultation Guidelines “The MHS no longer recognizes consultation codes (99241-99245 and 99251-99255). Providers will use either a new patient or established patient E&M service, depending upon the setting (inpatient or outpatient) and if the patient has previously been seen by a privileged provider of the same specialty at the same facility.” Shouldn’t the examples under 9.6.2. Non-Attending Inpatient Professional Service, “Use codes 99251-99255 when a physician provides an initial opinion or gives advice on the evaluation or management of a specific problem at the request of another physician,” be 99221-99223?
- **A:** Yes, this was missed in editing this version of the guidelines.



Army Q&A #1

- **Q:** Due to congressional funding acts, there have been research grants given to outside agencies to study varying treatments on soldiers returning from war zone duty. One particular study is Metronome Therapy (15 sessions including Neurobehavior Testing). Another study underway at Fort Carson is the Rudd Research Study in Behavior Health. Some of these researchers are entering notes into AHLTA. The coders, knowing that these providers are being paid from other funding, are being asked to also knowingly bill TRICARE. It would be prudent for PASBA to address this situation as soon as possible, in order to provide guidance to research providers and also to the Army staff who are offering assistance to complete the project. As a coder, I do not believe it is appropriate for research staff to enter notes into AHLTA, however, this decision is ultimately up to PASBA. Please advise.



Army Q&A #1

- **A:** The key is why the patient is being seen for the encounter. Per DoD 6013, Clinical investigations are covered in MEPRS FAH; if the reason the patient presents for the encounter is for the clinical trial, then the encounter should be placed in FAH. If the reason for the encounter is for management of the underlying problem and not the clinical trial, then it could be coded in the B clinic. This follows CMS's guidance for clinical trials, which states that CMS will not reimburse for services performed that are a requirement of the clinical trial, but will reimburse for conventional care and reasonable/necessary care for arising from the provision of the investigational item or service, such as effects or complications.



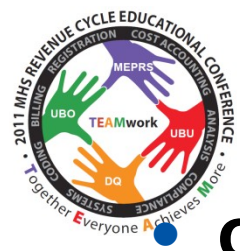
Army Q&A #2

- **Q:** The Chief of an Army Battalion wants to document her patient's immunizations in Medpros, to avoid duplicating her documentation efforts she would like to forgo documenting in AHLTA the EMR for DOD. Can she do so?
- **A:** No. Per MHS Coding Guidelines 5.10, “It is insufficient to simply select corresponding CPT codes in AP section of AHLTA note. Although this information may be reported in a different system, documentation must be contained in the note.” Also, AR 40-66, 5-19 specifies that the following: “Active duty, USAR, and ARNGUS Soldiers and deployable civilians will have their immunizations documented in AHLTA. When AHLTA is not available, immunizations will be recorded on DD Form 2766, or electronic equivalent, and entered in the MWDE module of MEDPROS. Non-active duty adult beneficiaries and non-deployable civilians will have their immunizations entered into AHLTA.”



Army Q&A #2

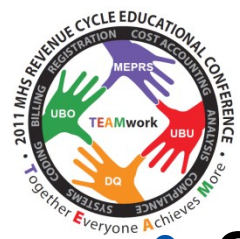
While MEDPROS is a valuable database helping to ensure AD readiness, it is not a substitute for AHLTA in recording immunizations when performed. It is considered appropriate to document the required information in the immunizations module in AHLTA, and document a brief note in the clinical encounters module describing that the immunization was given, as well as the patient's state of health at the time of the encounter, and any reaction to the immunization. For deployment and readiness related immunizations, the local MEPRS expert should be consulted as to the appropriate capture of immunization workload by MEPRS code.



Army Q&A #3

Q: If the provider clicks on 50% of time spent “counseling and/or coordinating care” and selects the appropriate amount of floor time face to face, is that enough to count as time in the therapy codes of mental health?

- **A:** No. Per MHS Coding Guidelines 6.8.5, “An entry in the hard copy outpatient medical record or AHLTA, about the mental health encounter should include items excluded from the psychotherapy note as defined in DoD 6025.18R, para DL1.1.29. *“Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”* MHS 6.8.3.3 also states the following: “For therapy, the time that face-to-face therapy started and time ended should be documented, because the therapy codes are time based. Time spent conducting the E&M component is not included in the therapy time.”



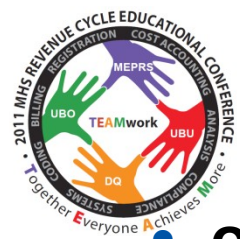
Navy Q&A #1

- **Q:** Clarify Section 5.1.2: “Non-Privileged Provider Procedures: When a non-privileged provider is granted permission by the MTF to do a procedure, the procedure code may be used to reflect nurse or technician services. Common examples are physical therapy technicians performing physical therapy procedures and technicians removing warts. In these cases, the technicians may only furnish the service if working under the written orders of a privileged provider.”
- **A:** So section 5.1.2 makes clear that the work of non-privileged providers is codeable, but it is actually silent on who gets to report this non-privileged provider work. Is it reported by the non-privileged provider, or is it, instead, reported by the privileged provider who is supervising the work of the non-privileged provider, with the non-privileged provider being reported as a secondary provider?



Navy Q&A #2

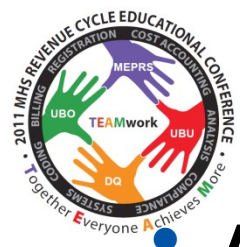
- **Q:** How are services reported when ER patients are routed to orthopedics for treatment?
- **A:** 1. Patient seen in ER; ER doc treats without manipulation:
 - ER doc reports 25500
- 2. Patient seen in ER; ER doc refers to ortho; ortho doc treats **without** manipulation:
 - ER doc reports E/M
 - Ortho doc reports 25500
- 3. Patient seen in ER; ER doc refers to ortho; ortho doc treats **with** manipulation:
 - ER doc reports E/M
 - Ortho doc reports 25505



Navy Q&A #3

- **Q:** How are services reported when Family Practice Clinic patients are routed to a casting clinic for treatment and ortho techs are involved?
- **A:** (1) Patient seen at family practice clinic, referred to ortho practice; under ortho doc's care, ortho tech treats **without** manipulation:
 - FP doc reports E/M
- What do you think is best practice?:
 - Ortho doc reports 25500-54 with tech as **secondary**
 - Tech reports 25500-54 with ortho doc as **secondary**
 - Tech reports 25500-54 with **no** secondary provider
- Any follow-up visits at the FP are reported by the FP doc with 25500-55
- Any follow-up visits with the ortho doc are reported by the **ortho** practice with 99024 *Postoperative visit*





Navy Q&A #3

- **A:** (2) Patient seen at family practice clinic, referred to ortho practice; under ortho doc's care, ortho tech treats **with** manipulation:
 - **FP** doc reports E/M
- What do you think is best practice?
 - Ortho doc reports 25505-54 with tech as **secondary**
 - Tech reports 25505-54 with ortho doc as **secondary**
 - Tech reports 25505-54 with **no** secondary provider
- Any follow-up visits at the FP are reported by the FP doc with 25505-55
- Any follow-up visits with the ortho doc are reported by the **ortho** practice with 99024 *Postoperative visit*